Dr KIRAN RANCHOD Registered Chinese Medicine Practitioner Tel: 0217628534
BPharm (UCT), BSc CHS, BCMA (UWC)Reg No: A1099Pr No: 0414123 Email: acutcm66@gmail.com

PATIENT QUESTIONNAIRE

FULL NAME AND SURNAME					
ADDRESS					
EMAIL					
CELL NO		TEL (H)		TEL (W)	
ID NUMBER	AGE	SEX M / F	MARITAL STATUS	CHILDREN	AGES
OCCUPATION					
MAIN COMPLAINT (duration, onset, better/worse, severity, quality)					
WESTERN MEDICINE DIAGNOSIS					
FAMILY HISTORY					
MOM	DAD	BROTHER	SISTER		
PATIENT MEDICAL BACKGROUND (eg BP, diabetes, cholesterol)					
MEDICAL HISTORY (drugs, herbal meds, vitamins and other supplements)					
PREVIOUS OPERATIONS					
DIET (breakfast, lunch, supper, preference for certain foods)					
BEVERAGES (how many glasses per day)					
Alcohol	Tea	Coffee	Sodas	Water	
EXERCISE (how many times per week and what exercise)					

SYMPTOMS	PLEASE CIRCLE or TICK APPROPRIATE SYMPTOM							
SWEATING	Night	Day	Profuse	Scanty	Watery	Oily	Smelly	
	Where:							
EYES	Red	Dry Floaters	Itching	Burning	Worse in light	Twitching	Light Sensitive	
EARS	Ringing	Deafness	Itchy					
STOOLS	Formed	Hard	Dry	Soft	Smelly			
	How often per day				Quantity			
URINATION	Awake at night to urinate	Pain with urination	Burning with urination	Smelly	How often			
DIZZINESS	Morning	Afternoon	Evening	Standing	Sitting	How often		
THIRST	Morning	Afternoon	Evening	Thirst for hot fluid	Thirst for cold fluid	How much liquid do you drink		
APPETITE	No appetite	Excess hunger	Craving sweet	Sour foods	Bitter foods	Salty foods	Pungent foods	Taste in mouth Sticky / bitter
EMOTIONS	Happy	Sad	Depressed	Frustrated	Angry	Frustrated	Sighing often	
SLEEP	Difficulty falling asleep		Pleasant dreams	Scary dreams	Waking often once asleep	Restless sleep		
ENERGY LEVELS	Tired in the morning	Tired in the afternoon	Tired in the evening	Tired after exercise				
NUMBNESS/ TINGLING/ LEG CRAMPS	Where			When		How often		
FEELING OF	Hot	Cold	Chills	Fever	Where			
CHEST	Pain	Discomfort	Cough	Palpitations	Tightness			
	When worse			Sinusitis	Alltergies	Phlegm		
ABDOMEN	Bloating after eating	Hiccups	Nausea	Belching	When worse			
HEADACHE	**When**	Lying down	Standing up					
	How often							
	Type	Sharp	Cold	Burning	Aching	Dull		
	Where	Top	Side	Front	Inside	Back		
	Worse	Angry	Sad	Cold / Hot	Pressure	With Menses	Wind	Damp
	Better	With pressure	Hot	Cold	Wind	Lying down	Standing	
PAIN	When							
	How often							
	Burning	Aching	Cramping	Stabbing	Dull	Sharp		
	Where							
	Better with pressure	Worse with pressure	Better for cold	Better for warmth	Where			
DIET	Favourite food or taste				Hunger with desire to eat			
	Excessive food craving				Lack of appetite			
MENSTRUATION	How long							
	Colour	Pale	Bright red	Dark	Dark red	Thick	Watery	Clots
	Pain	PMS	Regular	Irregular	Menopause			
MEN	Urinary problems	Impotence	Premature ejaculation	Loss of libido	Genital pain	Itching	Discharges	STD

Consent: I, _____, agree to allow the practitioner to perform the following treatments as explained and will not hold him liable for any discomfort, pain, incorrect diagnosis thereafter and if there is libel that it will be addressed with the practitioner first. I agree to pay the practitioner in full for all procedures and examinations performed and am liable for costs incurred.

Sign: _____ Date: _____